(2) Prior to any enrollment in benchmark or benchmark-equivalent coverage, the State must inform the exempt individual of the benefits available under the benchmark or benchmark-equivalent benefit package and the costs under such a package and provide a comparison of how they differ from the benefits and costs available under the standard full Medicaid program. The State must also inform exempt individuals that they may disenroll at any time and provide them with information about the process for disenrolling.

(3) The State must document in the exempt individual's eligibility file that the individual was informed in accordance with this section prior to enrollment, was given ample time to arrive at an informed choice, and voluntarily and affirmatively chose to enroll in the benchmark or benchmark-equivalent benefit package.

(4) For individuals who the State determines have become exempt individuals while enrolled in benchmark or benchmark-equivalent coverage, the State must comply with the requirements in paragraphs (a)(1) through (a)(3) of this section above within 30 days after such determination.

(b) *Disenrollment Process.* (1) The State must act upon requests promptly for exempt individuals who choose to disenroll from benchmark or benchmark-equivalent coverage.

(2) The State must have a process in place to ensure that exempt individuals have access to all standard State plan services while disenrollment requests are being processed.

(3) The State must maintain data that tracks the total number of beneficiaries that have voluntarily enrolled in a benchmark plan and the total number of individuals that have disenrolled from the benchmark plan.

§ 440.325 State plan requirements: Coverage and benefits.

Subject to requirements in §§ 440.345 and 440.365, States may elect to provide any of the following types of health benefits coverage:

(a) Benchmark coverage in accordance with § 440.330.

(b) Benchmark-equivalent coverage in accordance with § 440.335.

§ 440.330 Benchmark health benefits coverage.

Benchmark coverage is health benefits coverage that is equal to the coverage under one or more of the following benefit plans:

(a) *Federal Employees Health Benefit Plan Equivalent Coverage (FEHBP—Equivalent Health Insurance Coverage).* A benefit plan equivalent to the standard Blue Cross/Blue Shield preferred provider option service benefit plan that is described in and offered to Federal employees under 5 U.S.C. 8903(1).

(b) *State employee coverage.* Health benefits coverage that is offered and generally available to State employees in the State.

(c) *Health maintenance organization (HMO) plan.* A health insurance plan that is offered through an HMO, (as defined in section 2791(b)(3) of the Public Health Service Act) that has the largest insured commercial, non-Medicaid enrollment in the State.

(d) *Secretary-approved coverage.* Any other health benefits coverage that the Secretary determines, upon application by a State, provides appropriate coverage to meet the needs of the population provided that coverage. States wishing to elect Secretarial approved coverage should submit a full description of the proposed coverage, (including a benefit-by-benefit comparison of the proposed plan to one or more of the three other benchmark plans specified above or to the State's standard full Medicaid coverage package under section 1905(a) of the Act), and of the population to which the coverage would be offered. In addition, the State should submit any other information that would be relevant to a determination that the proposed health benefits coverage would be appropriate for the proposed population. The scope of a Secretary-approved health benefits package will be limited to benefits within the scope of the categories available under a benchmark coverage package or the standard full Medicaid coverage package under section 1905(a) of the Act.

§ 440.335 Benchmark-equivalent health benefits coverage.

(a) *Aggregate actuarial value.* Benchmark-equivalent coverage is health